LOS ANGELES COUNTY - DEPARTMENT OF HEALTH SERVICES
ALCOHOL & DRUG PROGRAM ADMINISTRATION
FEE FOR SERVICE (RESIDENTIAL AND NON-RESIDENTIAL)
PROPOSITION 36 USE ONLY

PROVIDER NAME: _____ CONTRACT NO.: _____

ADDRESS: _____ CLAIM PERIOD: _____

CITY: _____ ZIP _____ DATE PREPARED: _____

SERVICE CATEGORY: _____ PROVIDER NO.: _____

CONTACT PERSON: _____ PHONE: _____

ORIGINAL ( ) SUPPLEMENTAL ( )

SECTION 1 - PROVIDER SERVICE SUMMARY

	A PAGE TOTALS	B ADMISSION DATE	C DEPARTURE DATE	D RESIDENT/ CLIENT DAYS	E OUTPATIENT INDIVIDUAL	F OUTPATIENT GROUP
1	Pg 2 Total					
2	Pg 3 Total					
3	Pg 4 Total					
4	Pg 5 Total					
5	Pg 6 Total					
6	Pg 7 Total					
7	Pg 8 Total					
8	Pg 9 Total					
9	TOTAL					

	SECTION II - GROSS AMOUNT REQUESTED	D RESIDENT/ CLIENT DAYS	E INDIVIDUAL	F GROUP	AMOUNT REQUESTED
10	Total Units Reported on this claim.				
11	FFS Rate/Contract Rate				
12	Units Times Rates (Line 10 X 11)				

SECTION III - REVENUE

13	Grants	$
14	Client Fees	$
15	Insurance	$
16	Other	$
17	TOTAL REVENUE	$

SECTION IV - NET AMOUNT REQUESTED

(NOT TO BE COMPLETED FOR NET PROGRAM CONTRACTS)

18	Gross Amount Requested (Line 12)	$
19	Total Revenue (Line 17)	$
20	NET AMOUNT (18 LESS 19)	$

Payment on this claim may be delayed or withheld if this request for reimbursement contains any errors or omissions.

COUNTY USE ONLY

Amount Requested: $ _____

Carry Forward Amount: $ _____

Total Amount Payable: $ _____

By_____ Date_____

LIMITED MONTHLY ALLOCATION

Total Amount Payable:

$_____LOT

By_____ Date_____

Authorized Signature _____ Date _____